Race, Ethnicity, and Diabetes Care: Where To From Here?

commentary

Leonard Jack, Jr, PhD, MS

Leandris Liburd, MPH

After reading essays entitled "Into the Heart of Darkness: Reflections on Racism and Diabetes Care," written by Dr. Robert M. Anderson,[1] and "The Healing Process: Reflections on African American History and Diabetes Care," written by Dr. Kimberly Dawn Wisdom,[2] we were moved to share our thoughts.

We congratulate the American Association of Diabetes Educators for recognizing the need to address this complex, sensitive topic. Providing an open forum through which AADE membership, subscribers to *The Diabetes Educator*, and others can provide comments and recommendations on the topic of racism and diabetes care will promote greater sensitivity to the quality of care delivered to ethnic minority populations.

Racism is a complex, systematic assumption of the inherent superiority of certain races, with consequent discrimination against persons from other races.[3] Racism implies that some groups of people who share certain commonalities (eg, physical, educational, geographical, racial, and occupational characteristics) perceive themselves as being superior to those who are different. As such, a particular race, for example, that shares similar characteristics and life experiences as a result of these characteristics can either covertly or overtly express discrimination to those perceived to be unlike themselves.

Anderson and Wisdom articulated the relevance of this topic and the need for health professionals to have open discussions among themselves. Health professionals who provide direct patient care (eg, physicians, diabetes educators, dietitians, and nurse practitioners) should first acknowledge that they are subject to misguided judgments driven by personal biases, preexisting beliefs, and misunderstandings. This first step is difficult for many of us in the helping professions because we intellectually reject such negative notions as racism and discrimination. People who have committed their lives and careers to improving health outcomes for others may not recognize the subtleties of their own racism and how it is perceived and internalized by their patients, so they deny that these views exist. Dr. Anderson's reflections are a powerful example of how this situation can occur.

From the Division of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, Atlanta, Georgia (Dr Jack and Ms Liburd).

This essay is a response to guest editorials written by Drs Robert M. Anderson and Kimberlydawn Wisdom addressing racism and diabetes care that were published in the November/December 1998 issue of *The Diabetes Educator*.

Correspondence to Leonard Jack, Jr, PhD, Division of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, Mailstop K-10, 4770 Buford Highway, NE, Atlanta, Georgia 30341-3724 (e-mail: ljj0@cdc.gov).

Reprint requests may be sent to *The Diabetes Educator*, 367 West Chicago Avenue, Chicago, IL 60610-3025.

Race has long been used as a criteria for determining how certain groups of people should be treated as human beings. Historically, experiences based on this antihuman perspective that certain races are inferior to others have deep roots in medical and psychological research. Published articles dating back to the early 1800s reported finding that race is linked to unfounded psychological disorders, diseases, level of intelligence, educational capacity, and race classification.[4,5] Findings from these types of studies were used to justify misguided alternative healthcare treatment given to African Americans and other minority groups. Many of these misconceptions still exist today. It is for this reason that we must move beyond simply race and learn more about the total person and his or her life experience. Scientific advances show that humans are one species, that races do not exist as biologically distinct entities, that there is comparatively little variation in genetic composition between geographically separated human groups, and that the phenotypic characteristics of races are a result of a small number of genes that do not relate closely to either behavior or disease processes.[6]

We believe that a person's ethnicity would serve as a better context from which to learn about individuals. *Ethnicity* refers to certain shared characteristics including ancestral and geographical origins, cultural traditions, and languages.[7,8] Ethnicity is a complex idea that is broader than race, but in practice, race and ethnicity have been used interchangeably. Shared characteristics among minority groups that are not recognized, understood, and accepted can become the stimulus for racism in diabetes care. Drs. Anderson and Wisdom both recommend continued dialogue that allows us to explore our perceptions, along with past and present behaviors, when interacting with ethnic groups other than our own.

Both authors suggested that having an understanding of the patients' experience with racism would facilitate the healing process, along with one's self-disclosure of racist views, perceptions, and beliefs toward other groups. We cannot separate life from health. There is a very real and constant interaction between life and health. Heath professionals must be careful to recognize the power of racism on patient counseling and on a person's ability to make and sustain behavior changes required for successful diabetes management. We believe it is critical to gather input from patients on matters beyond dietary intake, level of physical activity, etc, to include life experiences (possibly racism) and how these experiences influence levels of psychological functioning and perceptions of patient-provider interaction.[10] Exploratory research into these areas would help to identify additional strategies to assist in patient education and counseling for minority populations.

It will not be enough to simply talk about the impact of racism and other life experiences among minority groups if we find ourselves conducting business as usual. Health professionals must be willing to challenge old thinking and practices. Other chronic disease researchers have explored the role of racism on patients' health (eg, hypertension, cardiovascular disease, and depression). This literature can be used as a springboard to facilitate our understanding of the impact of racism on diabetes care, from both a patient and caregiver perspective. Diabetes educators are ideally suited to accept and master the challenge of becoming historical and cultural translators in their interactions with patients, family members, and the community.[11] This does not minimize the role other health professionals play in the delivery of outpatient care. We each have a responsibility to eliminate racism in the delivery of diabetes care.

REFERENCES

1. Anderson RM. Into the heart of darkness: reflections on racism and diabetes care. Diabetes Educ. 1998;24:689-692.
2. Wisdom K. The healing process: reflections on African-American history and diabetes care. Diabetes Educ. 1998;24:689-692.
3. Mantague A. A Man's Most Dangerous Myth: The Fallacy of Race. New York: Columbia University Press; 1942.
4. Gold SJ. The Mismeasure of Man. London, England: Pelican Press; 1984.
5. Barkan E. The Retreat of Scientific Racism. London, England: Cambridge University Press; 1992.
6. Kuper L, ed. Race, Science and Society. London, England: Allen and Unwin; 1975.
7. Cruikshank JK, Beevers DG. Ethnic Factors in Health and Disease. Oxford, England: Butterworth-Heinemann; 1989.
8. Ahmad WIU, ed. "Race" and Health in Contemporary Britain. London, England: Open University Press; 1993.
9. Huth EJ. Identifying ethnicity in medical papers. Ann Intern Med. 1995;122: 619-621.
10. Jack L, Liburd L, Vinicor F, Brody G, McBride V. The influence of the environmental context on diabetes self-management: a rationale for developing a new research paradigm in diabetes education. Diabetes Educ. 1999;25:775-790.
11. Murphy F, Anderson R, Edgar L. Diabetes educators as cultural translators. Diabetes Educ. 1993;19: 113-118.